PRINTED: 04/16/2015 FORM APPROVED

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DAT	O. 0938-0391 E SURVEY IPLETED
		445268	B. WING		,		С
NAME OF P	ROVIDER OR SUPPLIER			67	IDEET ADDRESS SITV STATE TIP SAFE	03	3/31/2015
	N HEALTH AND REHABIL	ITATION CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 31 CASTLE HEIGHTS COURT EBANON, TN 37087		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
SS=G	conducted on 3/17/15 deficiencies were cite #35334. Deficiencies complaint #35184. 483.20(d), 483.20(k)(* COMPREHENSIVE CARE PINTERIOR CARE PI	d related to complaint were cited related to  1) DEVELOP CARE PLANS  results of the assessment d revise the resident's of care.  Iop a comprehensive care that includes measurable bles to meet a resident's mental and psychosocial ed in the comprehensive  escribe the services that are in or maintain the resident's ysical, mental, and ag as required under rices that would otherwise 3.25 but are not provided xercise of rights under right to refuse treatment  is not met as evidenced ord review and interview, yelop an individualized lan that provided specific	F 2	2279	F 279. Develop Comprehensive Care Plans  1. Resident identified in alleged deficient practice no longer resides in facility.  2. Residents residing in facility with pressurulcers have the potential to be affected by this alleged deficiency. Audit of Skin and pain care plans performed by DON /unit manager/MDS Nurse on Residents residing currently in facility with skin issues to include interventions to present the existing wounds and pain managem of current wounds. In-servicing with Licensed Nurses related to developing comprehensive care plan for skin concerns and pain by DON/Unit manager/Unit manager.  3. Initial and comprehensive care plans related to pain management and skin issues will be reviewed and discussed with IDT in morning meeting Monday through Friday. DON/ADON Manager/MDS Coordinator will review to valid care plans are in place, appropriate for Reside reviewed, and updated as needed.  4. Concerns found in morning meeting will addressed immediately with Licensed Nursing personnel to make immediate corrections as needed. Results of audit will be reported mon x 3 to the QAPI committee, consisting of Administrator, DON, ADON, Unit Manager, Soc Services Director, Medical Director, Dietary Manager, Maintenance Manager, Activities Director, and Medical Director.	y event ent care  ted  /Unit date nts	05/10/2015
ABORATORY D	IRECTOR'S OR PROVIDER/SU	JPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445268	B. WNG			C 03/31	
	ROVIDER OR SUPPLIER  I HEALTH AND REHABIL	ITATION CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 11 CASTLE HEIGHTS COURT EBANON, TN 37087	1 03/	31/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	990	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 279	ulcers and failed to p individualized interver management needs for resident of 5 residents ulcers. The facility's formprehensive care pto Resident #2.  The findings included Medical record review admitted on 10/4/11, a discharged on 10/20/record review revealed Anemia, Hyperlipidem Hypothyroidism, Pneudiffection, Arthritis and Medical record review comprehensive care prevealed an update of left medial buttock"; upon 10/18/14 to reflect slough depth, underm 3.0 cm (centimeter)."  Medical record review plan revealed interver pressure reduction curchair frequently for coreduction, turn and refrequently, provide indicating assessment for the side of	rovide specific and ntions to meet pain or one (Resident #2) is reviewed for pressure failure to develop a colan resulted in actual harm of a revealed Resident #2 was readmitted on 5/7/12, and 14. Continued medical diagnoses including hia, Depression, amonia, Urinary Tract of Coronary Artery Disease.  If of the resident's colan for pressure ulcers in 8/8/14 to reflect a "Stage II pdate on 9/8/14 to reflect a date on 10/5/14 to reflect attock with eschar"; update "right buttock with eschar ining, foul odor 3.5 x 3.0 x of the comprehensive care nations included: apply sattress to bed, apply shion to chair, reposition in memort and pressure ulcer position while in bed continence care, measure easily using the pressure ulcer form, complete a full body cument, pressure ulcer	F	2279			

STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	1	0. 0938-0391
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD				SURVEY
		445268					С
NAME OF P	ROVIDER OR SUPPLIER	445268	B. WNG	_		03/	31/2015
	HEALTH AND REHABIL	LITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 731 CASTLE HEIGHTS COURT LEBANON, TN 37087		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 279	Continued From page	2	F	279			
	pressure ulcer interver care plan to treat exist.  Medical record review. Check dated 7/28/14 an abrasion to the left. Review of a facility Included 8/8/14 revealed area on her left medical abrasion"  Review of a facility Included 9/8/14 revealed has increased in size. Review of the Weekly dated 9/21/14 revealed III pressure ulcer (1.4 a Stage II pressure ulcer (1.0 and a Stage II pressure ulcer (1.0 and a Stage II pressure the left buttock. Review of the Weekly dated 10/6/14 revealed III pressure ulcer (1.0 and a Stage II pressure	plan revealed no specific entions were provided on the ting pressure ulcers.  If of a Head to Toe Skin revealed documentation of buttock.  Cident/Accident Report I an injury of an "open					
	the left buttock.  Medical Record review Ulcer Record dated 9/	v of the Weekly Pressure 26/14 revealed					

STATEMENT OF	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION	(X3) DATE SI COMPLE	
		445268	B. WNG			200000	C
LEBANON	PROVIDER OR SUPPLIER  N HEALTH AND REHABI	odkalente taken statoven savjetski kolonik i stolje i kolonik s		731 (	EET ADDRESS, CITY, STATE, ZIP CODE CASTLE HEIGHTS COURT BANON, TN 37087	<u>  US</u>	3/31/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	200	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	documentation of a p 0.2) to the right butto stage documented) at (1.4 x 1.0 x 0.4) to the inside".  Medical record review Ulcer Record dated 1 documentation of a p to the "coccyx closes bed black in color" ar (1.9 x 2.6 x 0.2) to the Medical record review transferred to a local "suspected wound necrotic tissue, sloug Review of the hospitative resident was admidecubitus ulcer in preand necrotic tissue	pressure ulcer (2.4 x 1.6 x ock "closest to outside" (no and a Stage III pressure ulcer the right buttock "closest to outside" (no and a Stage III pressure ulcer the right buttock "closest to outside", "coccyx wound and a Stage II pressure ulcer the right buttock.  We revealed Resident #2 was a hospital on 10/20/14 due to infection with foul odor, gh and purulent drainage."  all medical record revealed inted with a "stage III be-sacral area with tunneling placed on a wound vac"  Trector of Nursing (DON) on in the DON's office by Pressure Ulcer Record sident's wounds and the bunds on the resident's care int.  We of the resident's plan related to pain dated on 7/17/14 and 10/7/14 is to provide scheduled pain dent for pain prior to py, if indicated, notify ions are not consistently analgesics as ordered and	F	279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY
		445268	B. WING				C
	ROVIDER OR SUPPLIER	BILITATION CENTER		731	REET ADDRESS, CITY, STATE, ZIP CODE  CASTLE HEIGHTS COURT BANON, TN 37087	1 03	31/2015
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	7027000000	ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE API DEFICIENCY)		JLD BE COMPLETION	
F 279	Continued From p	age 4	F	279			
	Administration Redocumented the formal documented the formal docum	tamin (Acetaminophen) 25mg tablet (Norco) 1 tablet hours scheduled hold for ed at 6:00 AM, 2:00 PM dered on 11/30/12.  taminoph 7.5-325mg tablet mouth twice daily PRN (as Ordered 2/16/14.There ation of the PRN medication and written note said "see pain					
	(Tylenol) (650mg) as needed pain (ra There was no doc medication on the note said "see pain Medical record rev Pain MAR dated 7 resident received as needed pain to the content of the con	50mg (2 tabs of 325 = 650mg) by mouth every 6 hours lated 1-5). Ordered 7/25/12. umentation of the PRN MAR- a hand written in flow sheet."  View of the PRN (as needed) 1/2014 documented the 1/2014 documented the 1/2015 a 7.5/325mg tablet of Norco on 1/2016 a 7.5/325mg tablet of pain					
	administration doc effective the medi- rated after administrated after administrated after administrated after administrated after the MAI resident did not re-	2. There was no post cumentation describing how cation was or what the pain was stration.  R dated 8/2014 revealed the ceive her scheduled pain (14 at 2:00 PM or 8/21/14 at					

	OF DEFICIENCIES CORRECTION	RECTION IDENTIFICATION NUMBER (X3) DATE SUI		3) DATE SURVEY COMPLETED		
		445268	B. WNG _			C 03/34/3045
	ROVIDER OR SUPPLIER  I HEALTH AND REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 731 CASTLE HEIGHTS COURT LEBANON, TN 37087		03/31/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR  (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 279	explaining why the rescheduled pain medi PRN Pain MAR provents of the 9/2014 did not receive her seg/5/14 at 10:00 PM,  Medical record reviete 9/1/14 at 12:30 AM responsitioning. Wound and dressing applied provided. Continued unsigned Nurse's Not documented "wou optifoam dressing apof pain and received medication" No PR documented as given wound care as order wound care as order Wedical record revieted (patient) c/o (complais being changedF sitting up"  Medical record revieted Note dated 10/6/14 relartfrequently yell.  Medical record revieted Data Set (MDS) with Date (ARD) of 10/7/2 received scheduled (as needed) pain medical pain	s no further documentation esident did not receive her ication. There was no 8/2014 ided by the facility.  4 MAR revealed the resident cheduled pain medication on or 9/28/14 at 6:00 AM.  w of a Nurse's Notes dated evealed "resident lying in f pain while turning and d to (L) (left) buttock cleaned I" No PRN pain medication review revealed an untimed, of dated 9/24/14 and to (L) buttock cleaned and oplied. Resident complained scheduled pain to the resident prior to red by the physician.  w of a Weekly Pressure 8/26/14 revealed "Pt ined of) pain while dressing Pt c/o [increased] pain when	F2	279		

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE	D. 0938-0391 E SURVEY PLETED
		445268	B. WING				C
	ROVIDER OR SUPPLIER  NHEALTH AND REHABII	LITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CO 731 CASTLE HEIGHTS COURT LEBANON, TN 37087			1 03.	/31/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	2000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 280 SS=D	pain or hurting freque it hard for her to sleep unable to answer if th day to day activities rowas unable to rate the scale. No further doct was noted on the MD An interview with the Administrator on 3/31 Conference Room co develop a comprehen interventions to preve pressure ulcers and a resident's pressure so develop a comprehen specific and individua management and resident #2.  483.20(d)(3), 483.10(i) PARTICIPATE PLANN  The resident has the incompetent or otherwincapacitated under the participate in planning changes in care and to the comprehensive assessinterdisciplinary team, physician, a registered for the resident, and of disciplines as determined.	The resident experienced antly and the pain had made to at night, and she was here were limitations in her related to pain. The resident repain on a 1-10 numeric furnentation regarding pain S.  Director of Nursing and /15 at 6:30 PM in the nifirmed the facility failed to reside the pain with specific and treat existing recurately reflect the redevelopment, failed to re		279	F 280. Right to Participate in Planning Care-RCP  1. Resident identified in alleged deficient practice no longer resides in facility.  2. New admissions/readmissions have pote to be affected by this alleged deficiency. Aud were performed on new current Residents admitted within the 30 days prior to 4/26/15 validate care plan are in place By DON/Unit Manager/MDS Nurse. Updates made as nece on current Residents to validate needs are reflected on Care Plans. In — servicing given to Licensed Nurses related to developing initial CP plan on admission/readmission.  3. New admissions/readmissions will be discussed in morning meeting Monday through Friday by IDT. Initial nursing Care Plans will be updated or created as need. New admissions be reviewed by	ential its to ssary Care	

AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY MPLETED
		445268	4				С
NAME OF P	ROVIDER OR SUPPLIER	1 443200	B. WNG			0:	3/31/2015
	HEALTH AND REHAB	ILITATION CENTER	0	73	REET ADDRESS, CITY, STATE, ZIP CODE 31 CASTLE HEIGHTS COURT EBANON, TN 37087		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BF	(X5) COMPLETION DATE
F 280	and revised by a teal each assessment.  This REQUIREMENT	ne 7 and periodically reviewed m of qualified persons after  T is not met as evidenced	F2	280	DON/ADON/Unit Manager or MDS Nurse to validate that Care Plan is in place.  4. Concerns found in morning meeting wi reported to monthly x 3 to the QAPI commit consisting of Administrator, DON, ADON, Un Manager, Social Services Director, Medical Director, Dietary Manager, Maintenance Ma Activities Director, and Medical Director.	tee, it	05/10/2015
	review, and interview the care plan to reflect wound care needs are revise the care plan a					(4)	
	admitted to the facility the hospital on 3/1/15 discharged back to the	w revealed Resident #1 was y on 2/27/15, discharged to 5, re-admitted on 3/5/15 and ne hospital on 3/16/15 with Pneumonia, Congestive ension, and Flaccid					
	(MDS) with an Assess (ARD) of 3/12/15 reve extensive assistance mobility and transfers for dressing, eating, to hygiene, and was total Review of the care plant.	w of the Minimum Data Set sment Reference Date ealed the resident required from 2 people for bed as, assistance from 1 person oileting, and personal eally dependent for bathing.  an development policy in the m with a revision date of					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		445268	B. WNG				С
	ROVIDER OR SUPPLIER I HEALTH AND REHABI	LITATION CENTER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 31 CASTLE HEIGHTS COURT .EBANON, TN 37087	1 03/	/31/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280	status in a holistic maresident's status, nee have an Initial Plan of hours of admission to identified risk areas a needsis developed received from the refordersclinical scree additional plan of car manually on paper by Team"  Medical record review of Care, effective data 3/11/15 revealed,"Frelated to: Pressure Upressure ulcer to sac place" Interventions care/preventative skin checks weekly per fafindings; Notify MD of emerging wounds; To decrease pressure pericare q2h (every 2 for incontinence"  Medical record review dated 3/6/15 revealed (wound medication) (gram) (Collagenase) topically every day shound, Cleanse with dry, cover wound bod santyl (wound bed of dressing, and change and PRN for soiling	s the review of the resident's annermust represent the edseach resident shall of Care developed within 24 of the facility that addresses and resident's initial individual dibased on information terring facility, physician and assessmentsany ele entries will be made by the [IDT] Interdisciplinary  Who of the Nursing Initial Plan ele 2/27/15 and signed on Potential/Actual Skin Issues Ulcer related to Incontinence, rum with treatment in a include "provide wound in care per order; Skin cility protocol, document of changes in wound or urn and reposition frequently electrically and provide to hours) and prn (as needed)  Who of a physician's order of a verbal order for "Santyl Dintment 250 Unit/GM Of Apply to Sacral Wound on the care with Sureprep, apply only), cover with Hydrocolloid and QOD (every other day)	F	280			

PRINTED: 04/16/2015 FORM APPROVED

STATEMENT	OF PERIODEN SIE	LIEBION IIB OCKVICES				OMB N	O. 0938-0391
AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		445268	B. WING				С
NAME OF P	ROVIDER OR SUPPLIER	200 (A1 - 2008)			TREET ADDRESS, CITY, STATE, ZIP CODE	03	/31/2015
. ==				323			
LEBANOI	N HEALTH AND REHABII	LITATION CENTER		335	31 CASTLE HEIGHTS COURT		
(X4) ID	CHMMADY CT	ATTEMPTION DE DESIGNATION DE LA CONTRACTION DEL CONTRACTION DE LA		-	EBANON, TN 37087		
PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 280	Continued From page	2 Q	_	000			
	P-3.	confirmed a newly admitted	F	280			
	resident is assigned t	o a specific nurse, and that					
	nurse is responsible f	for initiating an interim care					
	plan within the first 24	4 hours. Continued interview					
	confirmed that when	a resident is re-admitted, the					
	complete admission p	process starts over.					
	including physician or	rders, assessments, and a					
	new or updated care	plan.					
	Intension with the DO	N 2/24/45 5 00 D14 :					
	the conference room	N on 3/31/15 at 5:20 PM in confirmed the Nursing Initial					
	Plan of Care dated 2/	27/15 did not contain					
	specific wound care in	nterventions for Resident #1					
	and had not be revise	ed or updated after the					
	3/5/15 re-admission to	o the facility.					
	Medical record review	v of Resident #5 revealed					
	the resident was read	mitted to the facility on					
	2/19/15 with diagnose	es including Aftercare for					
	Healing Traumatic Fra	acture of Hip, Diabetes					
	Mellitus, Congestive I	Heart Failure, Atrial					
	Fibrillation (abnormal	heart rhythm), Muscle					
	Weakness and Difficu	ilty in Walking.					
	Medical record review	of Nursing Admission Data					
	Collection dated 2/19/	/15 revealed "Skin					
	Assessment: Coccyx,	Skin Shearing, 7 x 2 cm;					
	Right Trochanter (hip)	), Surgical Incision, 30x 1					
	cmLeft Heel, Press	ure, 3 x 2 cm,					
	Unstageable"						
	Modical reserve ver	of Noveley Lewis St					
	Care initiated on 12/2	of Nursing Initial Plan of /14 and revised on 3/17/15					
		ntial/actual skin issues					
	Interventions: Provide	de wound care/preventive					
	skin care per order (in	nitiated 12/2/14) Treatment					
	as ordered (date initia						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445268	B. WING	y		2010/08/20	C
	ROVIDER OR SUPPLIER  I HEALTH AND REHABII	LITATION CENTER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 31 CASTLE HEIGHTS COURT .EBANON, TN 37087	1 03	/31/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE
F 280	Continued From page	e 10	F.	280			
	dated 2/27/15 revealed with wound cleaner, protectant) to wound (topical ointment aids bed only and cover with day (QOD) and as new Medical record review dated 2/27/15 revealed	v of Physician's Orders ed "Sacrum Cleanse with					
	wound cleaner, pat di borders, apply Santyl cover with dry dressin	ry, apply SurePrep to wound to wound bed only and ng QOD and PRN"					
	dated 3/3/15 revealed with wound cleaner, p	or of Physician's Orders I "Right Hip Cleanse that dry, coat staple line with with long boarder gauze RN for soiling"					
	dated 3/3/15 revealed with wound cleaner, p wound borders, apply apply Alginate (an abs	of Physician s Orders If "Left HeelCleanse to the distribution of the control of the control Santyl to wound bed only, sorbent wound dressing), the control of the c					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		445268	B. WING			5.00	C
	ROVIDER OR SUPPLIER	LITATION CENTER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 31 CASTLE HEIGHTS COURT LEBANON, TN 37087	03/	31/2015
(X4) ID PREFIX TAG			1 No. 10 (1971)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPL DEFICIENCY)		D BE COMPLETION	
F 280	Continued From page	e 11	F	280			
		v of TAR dated led no documentation of ered to the left sacrum on					
		v of TAR dated led no documentation of ered to the left heel on					
	Medical record review of TAR dated 3/1/15-3/31/15 revealed no documentation of wound care administered to the left sacrum until 3/4/15 and then again on 3/11/15.						
	wound care administe	v of TAR dated led no documentation of ered to the right hip on /15, 3/13/15 and 3/18/15.					
	the Conference Room Resident #5 was not readmission to the far further confirmed that	N on 3/31/15 at 6:00 PM in n confirmed the care plan for revised upon the resident's cility on 2/19/15. The DON the resident's care plan and not revised until 3/17/15.					
	the resident was adm 3/12/15 with diagnose	es including Gout, Recent erebrovascular Accident,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		445268	B. WNG			С	
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 731 CASTLE HEIGHTS COURT LEBANON, TN 37087	DDE	03/31/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		ON SHOULD B HE APPROPRIA		
F 280	Continued From pag	e 12	F	280			
	dated 3/12/15 reveal HeelSureprep QD : ButtockCleanse wi	w of Wound Care Orders ed "Right and Left and PRNRight th WC, pat dry, apply Dry Dressing and change					
	Care dated 3/12/15 r potential/actual skin i Skin checks weekly r and reposition freque No interventions add	ssuesInterventions: " per facility protocol Turn ently to decrease pressure" ressing the resident's pressure ulcer treatment					
	3/27/15 revealed " pressure ulcersSta	w of the Care Plan dated admitted with several ge III Right Buttock and ral HeelsAdminister and observe for					
	3/31/15 revealed " WC, pat dry, apply Al Dressing and change 3/12/15"Continued	review of the TAR revealed at pressure ulcer care was					
	the Conference Roor plan dated 3/12/15 fo	ON on 3/31/15 at 6:00 PM in m confirmed the interim care or Resident #6 did not s pressure ulcer treatment					

PRINTED: 04/16/2015 FORM APPROVED

STATEMENT	OF DEFICIENCIES	AND DECLES OF THE PROPERTY OF			Material program and Change Const.	OMB N	O. 0938-0391
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY IPLETED
		445268	B. WNG			٠,	C
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03	3/31/2015
LEBANIO					31 CASTLE HEIGHTS COURT		
LEBANO	N HEALTH AND REHABIL	ITATION CENTER					
(X4) ID	CHMMADV CT	ATEMENT OF DESIGNATION			EBANON, TN 37087		
PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	00000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E ATE	(X5) COMPLETION DATE
F 280	Cartinus I F	10.20					
F 200	Continued From page	: 13	F	280			
	needs.				F 309. Provide Care/Services for Highest We	11-	
F 309		RE/SERVICES FOR	F	309	Being		
SS=G	HIGHEST WELL BEI	NG			1 0 1 10 1		
	2000 (000) (014) (020 VIII VIII VIII				Resident #2 identified in alleged deficier  practice no longer resides in facility.	ıt	
	Each resident must re	ceive and the facility must			practice no longer resides in facility. Resident #3 identified in alleged deficient pra	ation	
	provide the necessary	care and services to attain			Wound care treatment orders reviewed by w	ound	1 1
	or maintain the highes	st practicable physical,			care physician. Orders confirmed and treatme	ent	
	mental, and psychoso	cial well-being, in			continued.	2023 Tel	1-
	accordance with the c	omprehensive assessment					
	and plan of care.				<ol><li>Residents residing in facility with skin</li></ol>		
					concerns and pain concerns related to skin iss have the potential to be affected by this alleg	ues	
					deficient practice. Audits performed of curre	ea	
	This DECLUDENCE				resident with identified skin concerns to valid		
		is not met as evidenced		- 1	orders are in place and implemented complet		
	by:				DON/Unit Manager/MDS nurses. Pain assess	ments	
	based on medical red	cord review, observation,			completed on current residents with skin con	cerns	
	weekly pressure ulcer	record review,		- 3	by DON/Unit Manager/charge nurses.		
	record review and int	conference attendance			3. In-servicing to Licensed Nurses by		
	obtain a physician's or	erview, the facility failed to			DON/ADON/Unit Manager on getting and		
	treatment for 1 (Resid	opt #3) residents of 7			implementing treatment orders and pain		
	residents reviewed or	nd failed to implement, and			management of residents with skin concerns.	. In-	
	modify pain managem	ent interventions for 1			servicing provided to CNA and other member	s of	
	(Resident #2) resident	of 7 residents reviewed for			IDT on signs and symptoms of pain and who t	D	
	pain management res	ulting in the resident's		- 1	report them to.		
	inability to maintain an	d reach her highest			Residents with identified wounds will be revie	haved	
	practicable well being	and causing actual harm to			weekly by IDT consisting of DON or Unit Mana		
	Resident #2.	and causing actual flam to			SSD, MDS nurse to validate treatment orders	in	
					place and pain is addressed. New admission/		
1	The findings included:				readmissions will be reviewed Monday through	şh	
	3				Friday in morning meeting to validate any		
	Medical record review	revealed Resident #2 was			identified skin concerns are being treated as needed and that pain is addressed.		
	admitted to the facility	on 10/4/11, was readmitted			necoco ano that pain is addressed.		
	on 5/7/12 and discharg	ged on 10/20/14 with		1	4. Concerns found in morning meeting will	be	
	diagnoses including A	nemia, Hyperlipidemia,			reported to monthly x 3 to the QAPI committee	e,	05/10/2015
	Depression, Hypothyro	oidism, Pneumonia, Urinary			consisting of DON, Administrator, Medical Dir	ector,	
	Tract Infection, Arthriti	s and Coronary Artery			Social Services Director, and Medical Records.		
	Disease.	, , , , , ,					
				- 1			

DEPAR	MENT OF HEALTH	AND HUMAN SERVICES			۲	KINTED	: 04/16/2015
		& MEDICAID SERVICES				MB NO	APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT COM	E SURVEY MPLETED
		445268	B. WING	i		1	C /31/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	31/2015
LEBANC	N HEALTH AND REH	ABILITATION CENTER			31 CASTLE HEIGHTS COURT EBANON, TN 37087		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 14	F:	309			
	Data Set (MDS) with Date (ARD) of 7/11/totally dependent repeople for transferr personal hygiene ar person for bathing. extensive assistant mobility and assistant The resident was as incontinent of urine bowel. The resident on scheduled pain represent on scheduled pain represent on scheduled pain represent was unable to a resident was unable to	ew of the Quarterly Minimum h an Assessment Reference 14 revealed the resident was equiring assistance from 2 ring, dressing, toileting, nd required assistance from 1 The resident required the from 2 people for bed ance from 1 person for eating. The sessed to be frequently and always incontinent of the was assessed to have been medication, and had received ain medication over the last 5 the resident answered for hurting in the past 5 days the serious of the pain. The the to answer if her day to day the decause of the pain. The the was documented as in caused by arthritis and in Evaluation revealed rest, dication administration the resident was unable to of the pain. The manner of the pain. The manner of the pain. The manner of the pain and frowning.  The Mental Status (BIMS) a 2 out of 15 signifying the the comprehensive care with a problem of potential pain, chronic disease to pain and musculoskeletal					

documented Approaches of Positioning/support;

#### PRINTED: 04/16/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 445268 B. WING 03/31/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 731 CASTLE HEIGHTS COURT LEBANON HEALTH AND REHABILITATION CENTER LEBANON, TN 37087 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 309 Continued From page 15 F 309 Administer analgesics as ordered; See physician orders; Implement pain management flowsheet: Observe resident for signs and symptoms of pain, including verbal expressions and nonverbal expressions (facial grimacing bracing, restlessness, rubbing, other) Frequency of monitoring QS (every shift); Notify physician if interventions are not consistently effective: Medicate resident for pain prior to treatments and therapy, if indicated; therapy referral as indicated. The care plan was updated on 10/7/14 with a problem of actual pain related to a skin ulcer/wound. A new intervention of "...scheduled pain meds (medications) was added at this time. Medical record review of a Medication Administration Record (MAR) dated 7/2014 revealed the following orders: Hydrocodone-Acetamin (Acetaminophen) 5mg (milligram)-325mg tablet (Norco) 1 tablet by mouth every 8 hours scheduled hold for sedation. Scheduled at 6:00 AM, 2:00 PM and 10:00 PM. Ordered on 11/30/12

medication

pain flow sheet."

Hydrocodone-Acetaminoph 7.5-325mg tablet (Norco) 1 tablet by mouth twice daily as needed for pain. Ordered 2/16/14. There

on the MAR- a hand written note said "see

Acetaminophen 650mg (2 tabs of 325 = 650mg) (Tylenol) (650mg) by mouth every 6 hours as needed pain (rated 1-5). Ordered 7/25/12. There was no documentation of the PRN medication on the MAR- a hand written

was no documentation of the PRN

note said "see pain flow sheet."

		AND HUMAN SERVICES  MEDICAID SERVICES				FORM	D: 04/16/2015 MAPPROVED
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DA	D. 0938-0391 TE SURVEY MPLETED
		445268	B. WING	}		0.2	C 3/31/2015
NAME OF	PROVIDER OR SUPPLIER	nie ce		1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	13 1120 15
LEBANC	)N HEALTH AND REH	ABILITATION CENTER			731 CASTLE HEIGHTS COURT LEBANON, TN 37087		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	Continued From pa	ige 16	F	309			
	dated 7/2014 revea 7.5/325mg tablet of a verbal complaint of There was no post a describing how effe what the pain was resident received an PM after facial grim.  Review of the MAR resident did not received and the received and the resident did not received and the resident did not received and the received and the resident did not received and the repositioning. Would and the received and the	14 MAR revealed the resident scheduled pain medication on , or 9/28/14 at 6:00 AM.  ew of a Nurse's Notes dated revealed "resident lying in of pain while turning and and to (L) (left) buttock cleaned ed" No PRN pain medication d review revealed an untimed.					

		AND HUMAN SERVICES & MEDICAID SERVICES				FOR	D: 04/16/2015 MAPPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	6 (C		IPLE CONSTRUCTION	(X3) D	O. 0938-0391 ATE SURVEY OMPLETED
		445268	B. WING	<b>-</b>		,	C 3/31/2015
	PROVIDER OR SUPPLIER  N HEALTH AND REH	ABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 731 CASTLE HEIGHTS COURT LEBANON, TN 37087	<u>`</u>	0/0 1/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETION DATE
F 309	Continued From pa	ge 17	F:	30	9		
	Note dated 10/6/14	ew of an Activities Progress revealed "not as s out in pain when awake"					
	an ARD of 10/7/14 received scheduled (as needed) pain m days, but had not reintervention for pain pain or hurting frequit hard for her to sle unable to answer if day to day activities	ew of the Quarterly MDS with revealed the resident had pain medication, and PRN edication within the last 5 eceived a non-medication. The resident experienced uently and the pain had made ep at night, and she was there were limitations in her related to pain. The resident the pain on a 1-10 numeric					
	Review of Nursing at 4:09 PM revealed dressing changed	Progress note dated 10/13/14 I "patient yelling while					
	Attendance Record "called son to info	isciplinary Care Conference dated 10/16/14 revealed rm ofwound decline and t yelling out and pain"					
	10/18/14 revealed ".	ew of a physicians order datedFoley cath (catheter) nosis): intractable pain"					
	dated 10/19/14 at 10	ew of a Nursing Progress Note 0:24 PM revealed I peri-careresident noted to					
	revealed the schedu	ew of the 10/2014 MAR alled pain was changed from every 8 hours to 7.5/325mg 1					

		AND HUMAN SERVICES  & MEDICAID SERVICES				FORM	: 04/16/2015 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G	(X3) DAT	. 0938-0391 TE SURVEY MPLETED
WANE OF		445268	B. WING			C 03/31/201	
	PROVIDER OR SUPPLIER  ON HEALTH AND REH	ABILITATION CENTER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 731 CASTLE HEIGHTS COURT LEBANON, TN 37087		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETION DATE
F 309	po TID (three times  Medical record revie 10/20/14 at 9:00 AN (Emergency Room) wound-eschar/sloud drainage-undermini  Review of an Interd Attendance Record "called son (approuncontrollable pain Daily Living) and dra  Interview with the D the Administrator or conference room conferen	daily) on 10/19/14.  ew of a physicians order dated of revealed "send toER of for evaluation of buttock gh-foul odor, ing-severe pain"  isciplinary Care Conference dated 10/20/14 revealed ox 11:45 AM)informed him of during ADL's (Activities of essing changes"  irector of Nursing (DON) and in 3/31/15 at 6:30 PM in the confirmed Resident #2 had to pressures ulcers during are, dressing changes, and all ailed to administer scheduled mes in August and 2 times in stillity documented the sened beginning 9/1/14 during to administer PRN esident was incontinent of and had a Stage II pressure documented on 9/8/14 and a licer to the coccyx 8/14. An order for a Foley itten until 10/18/14. The DON ent did not receive PRN pain veri-care or pressure ulcer iding medication after the sethe resident's pain or t well being. The facility failed an in a timely manner the	F	309			

harm to Resident #2.

		AND HUMAN SERVICES  & MEDICAID SERVICES				<b>FORM</b>	04/16/2015 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	0938-0391 E SURVEY IPLETED
		445268	B. WING				C <b>31/2015</b>
	PROVIDER OR SUPPLIER  N HEALTH AND REH	ABILITATION CENTER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 31 CASTLE HEIGHTS COURT EBANON, TN 37087		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOLICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 19	F	309			
	the resident was res 3/3/15 with diagnos Difficle, Chronic Kid	ew of Resident #3 revealed admitted to the facility on es including Clostridium Iney Disease, Generalized ness, Anemia and Diabetes					
	dated 3/9/15 revea Cleanse with warm cover with Optifoam	ew of Physician's Orders led "Right outer calf water and soap, pat dry and i (an absorbant dressing) ay) and PRN (as needed)for					
	at 1:40 PM in the Re	nd care treatment on 03/19/15 esident's room revealed LPN Alginate (an absorbant vound.					
	resident's room who the wound, LPN #2	#2 on 3/19/15 1:46 PM in the en asked what was placed on stated "Calcium Alginate. I for it, but I will call the doctor			a a		
	the DON's office, who of orders for Calcium confirmed there were Calcium Aginate and Physician's Order by 483.25(c) TREATM	ENT/SVCS TO	F3	314			
		rehensive assessment of a must ensure that a resident			F314. Pressure Sores		

1. Residents identified by alleged deficient

practice no longer reside in facility.

CENTE		& MEDICAID SERVICES			0	FORM	APPROVED 0. 0938-039
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		445268	B. WING			03	C / <b>31/2015</b>
	PROVIDER OR SUPPLIER  N HEALTH AND REH	ABILITATION CENTER		7:	TREET ADDRESS, CITY, STATE, ZIP CODE 31 CASTLE HEIGHTS COURT EBANON, TN 37087	1 03	13112015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	does not develop prindividual's clinical of they were unavoidal pressure sores recesservices to promote prevent new sores for this REQUIREMENT by:  Based on medical review, review of factive facility failed to prevent and provide the necessary ulcers for 2 (Resider of 5 residents review to prevent and providulcers resulted in active provide the necessary ulcers resulted in active provide the necessary ulcers resulted in active prevent and providulcers resulted in active prevent and discharged in the findings included the facility of the findings included admitted to the facility on 5/7/12 and discharged in the findings including active prevent and the facility of the Skin Market in the facility of the Skin	ty without pressure sores essure sores unless the condition demonstrates that ole; and a resident having ives necessary treatment and healing, prevent infection and rom developing.  T is not met as evidenced ecord review, facility policy cility Incident/Accident reports, cer Logs, and interview, the ent, implement, monitor, and my treatment for pressure at #1, Resident #6) residents yed. The failure of the facility de care to treat pressures that harm to 2 (Resident #2, ats of 5 residents reviewed	F 3		2. Residents residing in the Facility with skin concerns have the potential to be affected by the alleged deficient practice. Skin assessments preformed on current residents residing in facility DON/ADON/Unit Manager/Charge Nurses. Audits will be done to validate prevention, implementation, monitoring and necessary treatment is in place completed by Don/Unit Manager/Charge Nurse/Treatment Nurse.  3. Skin audits will be scheduled Sunday through Thursday and will be reviewed in Morning meeting Monday through Friday. Any not completed will done immediately and education provided to Licensed Nurses. Treatment nurse is currently in place to oversee treatment implementation and documentation. Second documentation review, Monday through Friday, conducted by DON/Unit Manager/ADON/MDS nurse. Education to Licensed Nurses related to wound staging, measuring of wounds, performing treatments, and documentation conducted by Micheal Britton Certified Wound Nurse and Dr. Powell Wound Care Physician with post-test competency. In-servicing to Ceritified Nurse Aide on early identification conducted by DON/Unit Manger/ADON/Wound Nurse. Ongoing, new hird will receive the same education/in-servicing.  4. Audits of TARS for residents with wounds we beconducted 3 times a week x 4 weeks. 2 times a week x 4 weeks, 2 times a week x 4 weeks, 2 times a week x 4 weeks. Concerns will be addressed/corrected upon discovery. Results of audit will be reported to the QAPI committee IDT, consisting of Administrator, DON, ADON, Unit Manager, Social Services Director, Medical Director, Dietary Manager, Maintenance Manager, Activities Director, and Medical Director, monthly x3.	gh ng be n es es	05/10/2015

		AND HUMAN SERVICES & MEDICAID SERVICES				<b>FORM</b>	: 04/16/2015 APPROVED
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G	(X3) DAT	. 0938-0391 E SURVEY IPLETED
		445268	B. WING	·		E	C <b>31/2015</b>
	PROVIDER OR SUPPLIER  ON HEALTH AND REH	ABILITATION CENTER		:	STREET ADDRESS, CITY, STATE, ZIP CODE 731 CASTLE HEIGHTS COURT LEBANON, TN 37087	00/	3112013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	Ongoing monitoring to ensure optimal re review revealed for positioning a reside whenever possible. Devices should be a pressure sore area. surface Establish a schedule based on condition Assess fradditional ulcers"  Medical record revied Data Set (MDS) with Date (ARD) of 7/11/totally dependent re people for transferr personal hygiene ar person for bathing. extensive assistant mobility and assistant The resident was as incontinent of urine bowel.  The Brief Interview is scored the resident resident was severe Review of the Brade Pressure Sore Risk resident an "11". A represents high risk Constantly moist; Cl	and evaluation are provided esident outcomes" Further bed bound residents "Avoid nt directly on a pressure ulcerUse positioning devices. used to completely raise theoff of the support an individualized turning the resident's clinical for risk of developing the resident's clinical for risk of developing the resident was quiring assistance from 2 ring, dressing, toileting, and required assistance from 1 The resident required e from 2 people for bed note from 1 person for eating. It is sees to be frequently and always incontinent of the scale for Predicting dated 7/11/14 scored the total score of 12 or less . Risk factors included;	F	314			

		AND HUMAN SERVICES  MEDICAID SERVICES				FORM	: 04/16/2015 APPROVED
STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G	(X3) DAT	. 0938-0391 E SURVEY MPLETED
		445268	B. WING	;			C /31/2015
	PROVIDER OR SUPPLIER  N HEALTH AND REH	ABILITATION CENTER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 731 CASTLE HEIGHTS COURT LEBANON, TN 37087	1 00/	01/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
F 314	Medical record revice comprehensive car an actual pressure moisture/incontinent friction and shear p "self inflicted scramedial buttock" I pressure reduction pressure reduction chair frequently for reduction; turn and frequently for comformation frequently for care plan was actual pressure ulcalled frequently	re plan revealed a problem of ulcer on 8/8/14 related to nee, impaired mobility and a problem, and described as atch/abrasion Stage II (L) (left) interventions included; apply mattress to bed; apply cushion to chair; reposition in comfort and pressure reposition while in bed ort and pressure reduction; are care after each incontinent and stage wound weekly using healing assessment form, by check weekly and document; as ordered; Registered ressure ulcer treatment as a li buttock ulcer, and again on lem of an unstageable (R) thill eschar. The interventions is as were present on 8/8/14. Supdated on 10/18/14 with an er to "(R) buttock continued in the interventions remain the tion of "NP (Nurse all to be seen 10/19/14 for	F	314			

		& MEDICAID SERVICES				FORM	APPROVED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) 141	II TID			0. 0938-0391
	OF CORRECTION	IDENTIFICATION NUMBER:			LE CONSTRUCTION	CON	TE SURVEY MPLETED
		445268	B. WING	3		S 255000	C
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	/31/2015
				1	731 CASTLE HEIGHTS COURT		
LEBANC	ON HEALTH AND REH.	ABILITATION CENTER		1	LEBANON, TN 37087		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	Review of a facility dated 8/8/14 revealed area on her left med abrasion" The Surdocumented "wou scratchhas long h lengthy nails and so Past Interventions A (not applicable). Re Interventions include apply skin barrier to treatments as order in size, odor, pain, of the measurement of as 1 x 0.2 cm of she Medical record revier revealed an order doptifoam (highly absomedial buttock q (evineeded)" There we wound care to the least 1, 8/20 or 8/29. The weekly skin asses 8/4, 8/11, or 8/18. To consecutive days wiskin assessment from Review of a facility I dated 9/8/14 revealed.	Incident/Accident Report and an injury of an "open dial buttock/self inflicted ammary of Investigation and appears to be a ard nailsnoted with thick aratches often" Attempted documented N/A commendations/New ad; "trim resident's nails; buttocks after incontinence; ad; observe area for increase drainage, Notify MD/NP" of the wound was documented ared skin.  and a TAR dated 8/1-8/31/14 ated 8/8/14 to "apply corbent dressing) to left arey) 3 days and PRN (as as no documentation of aft medial buttock on 8/14, and an injury documented as an 8/12-8/23/14.  ancident/Accident Report and an injury documented as	F	314			
	"wound on left but description of the sit from a scratch on le sizemeasures2.2 The Summary of Inv "noted followup sta	tock has increased" The uation documented "wound ft buttockincreased in 2 cm x 3.6 cm no depth" restigation documented age 2 next to self inflicted at Interventions Attempted					

DELVIZIMENT OF TIEVETTIVIAD HOMAN SELVICES

		& MEDICAID SERVICES				FORM	APPROVED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIP	LE CONSTRUCTION		. 0938-0391 E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:					MPLETED
		445268	B. WING				С
NAME OF F	PROVIDER OR SUPPLIER	440200	D. Wille		STREET ADDRESS, CITY, STATE, ZIP CODE	03	31/2015
LEDANO	M HEALTH AND DEN	ADILITATION CENTED			731 CASTLE HEIGHTS COURT		
LEBANO	IN REALITH AND REH	ABILITATION CENTER		1 5	EBANON, TN 37087		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	documented "Opt days after being cle cleaner). Recommincluded; "Clean [thera-honey and co Mon, Wed & Friday air mattress 9/9/14.  Review of a Weekly dated for the week or resident had a Stag buttock measuring but positive for drair III pressure ulcer to 1.0 x 0.4 with no odd.  Medical record revier revealed the weekly documented as com 9/26/14.  Medical record dated to the "coccyx closunstageable pressured to the "coccyx closured to the "coc	ifoam was being applied q 3 an [with] W/C (wound endations/New Interventions with] W/C, pat dry, apply ver [with] Optifoam every & PRN; Resident placed on	F	314			
1	Medical record revie	w of a TAR dated					

DELAIVEMENT OF HEALTH AND HOMAN SEKVICES

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			0		. 0938-0391	
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
1997 ac 1918 best 1		445268	B. WING				C / <b>31/2015</b>	
	PROVIDER OR SUPPLIER  ON HEALTH AND REHA	ABILITATION CENTER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 31 CASTLE HEIGHTS COURT EBANON, TN 37087		31/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
	assessments were on 10/6 or 10/13/15 10/5/14 to "Cleans [with] W/C, apply Sadead tissue from wo [with] maxorb rope (absorbs moderate to [with] optifoam" was completed on 10/16 to "Cleanse (R) but apply hydrogel (help environment) and condocumented as com 10/18/14.  Medical record revies 10/20/14 revealed "Room) for evaluation wound-eschar/sloug drainage-undermining debridement potential.  Interview with the DO the DON's office combeen responsible for weekly skin assessmesidents, and documented to the property of the property	not documented as completed by A physician's order dated se inner area @ (at) coccyx antyl (medicine that removes ounds) to wound bed, pack (alginate wound dressing that to heavy drainage), cover as not documented as 6/14. Continuation of the order attock outer area [with] W/C as create and maintain a moist over daily and PRN" was not impleted on 10/16 and ew of a physicians order datedSend toER (Emergency on of buttock gh-foul, ingevaluation for ial"  ON on 3/18/15 at 4:00 PM in infirmed the staff nurses had a rassessing and documenting ments on their assigned menting the Weekly Pressure a resident was known to have the DON stated, "The nurses tage a woundwe need a t nurse."	F3	14				
	the conference room to Toe Skin Checks	ON on 3/30/15 at 4:00 PM in n confirmed the weekly Head should be completed on all and interview confirmed the						

FORM APPROVED

CLIVIL	NO I ON WILDICANE	& MEDICAID SERVICES				WR NO	. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		445268	B. WING			The second	C /31/2015
NAME OF PROVIDER OR SUPPLIER  LEBANON HEALTH AND REHABILITATION CENTER			7	STREET ADDRESS, CITY, STATE, ZIP CODE 31 CASTLE HEIGHTS COURT LEBANON, TN 37087			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL JLATORY OR LSC IDENTIFYING INFORMATION)		ıx	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	Interview with LPN the conference roor	ge 26 not completed as ordered. #1 on 3/31/15 at 1:10 PM in m confirmed the Head to Toe vas to be completed upon	F	314			
	whether they had a interview confirmed Check was also to b on a weekly basis for	kly thereafter on all residents wound or not. Continued the weekly Head to Toe Skin be documented on the MAR or those residents that had red by the physician.					
	conference room co and chair bound and her care and mobilit the resident frequen	1 on 3/31/15 at 1:50 PM in the onfirmed Resident #2 was bed d was dependent on staff for cy. The RN confirmed seeing of the laying in a geri-chair in a mped to one side or the					
	the conference room not receive weekly hassessments as ord there was no docum	lered. The DON confirmed nentation on 8/4, 8/11, 8/18, 29/14 the resident received a			2		
	resident had a docu self-inflicted abrasio measuring 1 x 0.2 c nailsscratches ofte	n to her left medial buttock m due to "long hard en" The DON confirmed the ttempted documented "N/A"					

FORM APPROVED

		& MEDICAID SERVICES					APPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLE CONSTRUCTION  G	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED			
445268			B. WING	3_		C 03/31/2015		
NAME OF I	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE			
LEBANON HEALTH AND REHABILITATION CENTER				1	731 CASTLE HEIGHTS COURT LEBANON, TN 37087			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 314	interventions includ The DON confirmed the residents nails injury on 7/8/14 or t Continued interview	ed to trim the residents nails. d there was no documentation had been trimmed after the he injury on 8/8/14.	F	314	4			
	to receive wound caevery 3 days and Placevery 3 day	are to the left medial buttock RN and there was no resident received wound care or 8/29/14. The DON at to the left buttock had a Stage II pressure ulcer. If by 9/28/14 the resident was a 2 pressure ulcers; the Stage and a Stage III to the coccyx or 0.4; by 10/5/14 the Stage III e buttock measured 1.9 x 2.6 occyx pressure ulcer x 3cm, was unstageable, and black. The DON confirmed are to both of these wounds 5/14, and there was no resident received pressure the coccyx on 10/16/14 and no ment was received to the 10/18/14. Continued interview med the resident was (Emergency Room) for k wound-eschar/slough-foul erminingevaluation for ial" on 10/20/14.						
	a result of the facility	with the DON confirmed as y's failure to trim the residents ssessments, and pressure completed as ordered,						

		AND HUMAN SERVICES  & MEDICAID SERVICES				FORM	APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X				PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
445268 B. WING		C 03/31/2015					
	PROVIDER OR SUPPLIER  ON HEALTH AND REHA	ABILITATION CENTER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 731 CASTLE HEIGHTS COURT LEBANON, TN 37087		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	Resident #2 suffere failed to prevent and measuring 1 x 0.2 counts a Stage II press measuring 1.9 x 2.6 ulcer to the coccyx Stage III and increas pressure ulcer with and undermining measuring 10/5/14 and increas 10/18/14. The reside on 10/20/14 for eval pressures ulcers as and provide the necessariant of the suffer suffer in the suffer	ge 28 d actual harm as the facility d treat a scratch to the buttock on 8/8/14 which developed sure ulcer by 10/5/14 b x 0.2 cm; a second pressure developed on 9/28/14 as a ased to an unstageable eschar, foul odor, drainage easuring 1.7 x 1.5 x 1 cm by sing to 3.5 x 3.0 x 3.0 cm by ent had to be sent to the ER duation and treatment of the the facility failed to prevent essary treatment for the lited in actual harm to t	F3	314			
	the resident was rea 2/19/15 with diagnos Healing Traumatic F Mellitus, Congestive Fibrillation (abnorma Weakness and Diffice Medical record review	ew of Resident #5 revealed admitted to the facility on ses including Aftercare for Fracture of Hip, Diabetes Heart Failure, Atrial al heart rhythm), Muscle culty in Walking.					
	potential/actual skin care/preventative sk 12/2/14)Treatmen 3/5/15)" Medical record revie Collection dated 2/1 Assessment: Coccy	issues Provide wound in care per order (initiated t as ordered (initiated ew of Nursing Admission Data 9/15 revealed "Skin x, Skin Shearing, 7 x 2 cm; p), Surgical Incision, 30 x 1					

		AND HUMAN SERVICES  & MEDICAID SERVICES					APPROVED 0. 0938-0391
AND PLAN OF CORRECTION   IDENTIFICATION NUMBER:				IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
445268		B. WING	<u> </u>			C /31/2015	
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		0.112010
LEBANC	N HEALTH AND REH	ABILITATION CENTER			731 CASTLE HEIGHTS COURT LEBANON, TN 37087		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 314	Unstageable "  Medical record reviet Initial Evaluation da III Pressure Wound Medical record reviet revealed no orders coccyx/left medial be 2/19/15 until 2/27/15 by the Wound Care Medical record reviet dated 2/27/15 reveat wound cleaner, pat protectant) to wound (topical ointment aid bed only and cover other day) and PRN Medical record reviet TAR revealed press sacrum was not doo 3/3 and 3/11/15.  Medical record reviet Skin Checks dated 2/27/15 reveated press sacrum was not doo 3/3 and 3/11/15.	ew of Wound Care Specialist ted 2/27/15 revealed "Stage on the Left, Medial Buttock"  ew of the physician's orders for wound care to the auttock/sacrum area from 5 when the resident was seen Specialist.  ew of a physician's order aled "Sacrum Cleanse with dry, apply SurePrep (skind borders, apply Santyles in wound healing) to wound with dry dressing QOD (every	F	3314			
	of Care with an adm revealed "has pote	ew of the Nursing Initial Plan dission date of 2/19/15 ential/actual skin s: Treatments as ordered"					
	the conference room did not call the physi	# 3 on 3/30/15 at 11:15 AM in n, when asked why the LPN ician on 2/19/15 to obtain eatment, the LPN stated, "I					

		AND HUMAN SERVICES  & MEDICAID SERVICES					APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	. 0938-0391 E SURVEY IPLETED
		445268	B. WING			0000000	C 31/2015
	PROVIDER OR SUPPLIER  N HEALTH AND REH	ABILITATION CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 31 CASTLE HEIGHTS COURT EBANON, TN 37087		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	Interview with LPN at the Conference Rocassessment is compound in the orders at The Nurses are responders. We call the orders or call the dollar the Conference Rochad no pressure ulcounterview with the Difference Rochad no pressure ulcountervie	upposed to get orders and put er."  # 1 on 3/31/15 at 1:10 PM in om revealed "The initial pleted within the first couple of at Director of Nursing (ADON) and we double check them. ponsible for checking the hospital, if needed, for other actor."  ON on 3/31/15 at 6:00 PM in om confirmed that Resident #5 are treatment orders from /19/15 until 2/27/15 when care specialist and then was Stage III pressure ulcer to the Continued interview taining and implementing pressure ulcer prevention acility failed to prevent a licer which resulted in actual	F	314			
	admitted to the facili the hospital on 3/1/1 discharged back to t	ew revealed Resident #1 was ity on 2/27/15, discharged to 5, re-admitted on 3/5/15 and the hospital on 3/16/15 with Pneumonia, Congestive tension, and Flaccid					
	Assessment Reference documented the res	num Data Set (MDS) with an name of the nam					

		& MEDICAID SERVICES			,	FORM	APPROVED 0. 0938-0391	
	FATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		William Walnut Cal		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		445268	B. WING	3_		03	C /31/2015	
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
LEBANO	N HEALTH AND REH	ABILITATION CENTER			731 CASTLE HEIGHTS COURT LEBANON, TN 37087			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
	transfers, assistance eating, toileting, and totally dependent for Medical record review of Care, effective da 3/11/15 revealed, ". related to: Pressure pressure ulcer to sa place" Intervention care/preventative sk checks weekly per faindings; Notify MD of emerging wounds; To decrease pressure pericare q2h (every findings; Notify MD of emerging wounds; To decrease pressure pericare q2h (every findings; Notify MD of emerging wounds; To decrease pressure pericare q2h (every findings; Notify MD of emerging wounds; To decrease pressure pericare q2h (every findings; Notify MD of emerging wounds; To decrease pressure pericare q2h (every findings; Notify MD of emerging wounds; To decrease pressure pressure q2h (every findings; Notify MD of emerging wounds; To decrease pressure pericare q2h (every findings; Notify MD of emerging wounds; To decrease pressure pericare q2h (every findings; Notify MD of emerging wounds; To decrease pressure pericare q2h (every findings; Notify MD of emerging wounds; To decrease pressure pericare q2h (every findings; Notify MD of emerging wounds; To decrease pressure pericare q2h (every findings; Notify MD of emerging wounds; To decrease pressure pericare q2h (every findings; Notify MD of emerging wounds; To decrease pressure pericare q2h (every findings; Notify MD of emerging wounds; To decrease pressure pericare q2h (every findings; Notify MD of emerging wounds; To decrease pressure pericare q2h (every findings; Notify MD of emerging wounds; To decrease pressure pericare q2h (every findings; Notify MD of emerging wounds; To decrease pressure pericare q2h (every findings; Notify MD of emerging wounds; To decrease pressure pr	e from 1 person for dressing, a personal hygiene, and was rebathing.  Ew of the Nursing Initial Plan ate 2/27/15 and signed onPotential/Actual Skin Issues Ulcer related to Incontinence, crum with treatment in as include "provide wound acin care per order; Skin acility protocol, document of changes in wound or furn and reposition frequently etry/dry and provide 2 hours) and prn for  Ew of a Weekly Pressure 2/28/15 completed by LPN #3 ce of a pressure ulcer to the suring 7 x .5 cm and d filled blister to left gluteal  Ew of a Nursing Admission essment with an effective date by LPN #2 revealed the er on a coccyx wound cm. Continued review rregular shape (butterfly skin peeling, area red, small to 9 o'clock"	F3	314				
	unstageable (due to the sacrum measuring	ed 3/5/15 revealed an necrosis) pressure ulcer of ag 6 x 8 x 0.3 cm. The wound rotic tissue, 20% granulation						
M CMC 256	7(02-99) Previous Versions O	bsolete Event ID: 1ECW/11	MINONEY 00 - 6.55	-	ocility ID: TNOSOO			

SELVINIERT OF THEVELLI VIAD HOMINIA SELVATOES

		& MEDICAID SERVICES					APPROVED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTI	IPLE CONSTRUCTION		0. 0938-0391 TE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:			IG		MPLETED
		445268	B. WING	3			C
NAME OF I	PROVIDER OR SUPPLIER	110200		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	03	/31/2015
					731 CASTLE HEIGHTS COURT		
LEBANON HEALTH AND REHABILITATION CENTER					LEBANON, TN 37087		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 314	tissue and 50% skir included "Santyl (Days and PRN, Hyd Two Days and PRN The facility could not follow-up notes from after 3/5/15.  Medical record revida 3/31/15 revealed a Ointment 250 UNIT Apply to Sacral Worevery other day for WC (wound cleaner boarder with Surepresently (wound bed dressing, and change PRN for soiling" Continued review rewound care/treatmes 3/11/15.  Interview with the Dathe conference room a physician's order dated 3/6/15 and not documented until 3/2 acknowledged the in assessments of the location i.e., 1 eft glut sacrum; the measure admission i.e., 7 x 1 difference in descrippeeling skin versus Medical record review.	n. The assessment and plan wound medication)-Every Two drocolloid (dressing)-Every with follow-up within 7 days. In the Wound Care Specialist of the Wound Care With Care with the Sacral wound Cleanse with the Care wound of the Order of the Wound The Order of the Wound The Order of the Was 3/6/15. On the Order of the Was noted on 3/7, 3/9, or on the Wound Care was noted on 3/7, 3/9, or on the Wound Care Specialist was noted on 3/7, 3/9, or on the Wound Care Specialist was noted on 3/7, 3/9, or on the Wound Care Specialist was noted on 3/7, 3/9, or on the Wound Care Specialist was noted on 3/7, 3/9, or on the Wound Care Specialist was noted on 3/7, 3/9, or on the Wound Care Specialist was noted on 3/7, 3/9, or on the Wound Care Specialist was noted on 3/7, 3/9, or on the Wound Care Specialist was noted on 3/7, 3/9, or on the Wound Care was noted on 3/	F	31	4		
	peeling skin versus  Medical record revie the resident was ad	unstageable due to necrosis.					To part of the par

Hip Fracture, Cerebrovascular Accident,

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/16/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING  C. MULTIPLE CONSTRUCTION  A. BUILDING  C. MULTIPLE CONSTRUCTION  A. BUILDING  STREET ADDRESS, CITY, STATE, ZIP CODE  731 CASTLE HEIGHTS COURT	URVEY ETED
NAME OF PROVIDER OR SUPPLIER  8. WING 03/31/2    STREET ADDRESS, CITY, STATE, ZIP CODE 734 CASTI E USICUTE COURT	2015
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  734 CASTLE HEIGHTS COURT	2015
LEBANON HEALTH AND REHABILITATION CENTER 731 CASTLE HEIGHTS COURT	
LEBANON, TN 37087	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CORRECTION SHOULD BE CORRE	(X5) OMPLETION DATE
F 314  Continued From page 33  Pneumonia and Deep Vein Thrombosis.  Medical record review of Nursing Admission Data Collection dated 3/12/15 revealed " Skin Assessment Right Buttock, Abrasion; Left Buttock, Abrasion; Right Thigh (rear), Surgical Incision; Right Ankle (outer), Bruising, 3.0 x 1.5 [cm]; Right Heel, Pressure, 3.5 x 4.8 [cm], Unstageable; Left Heel, Pressure, 1.5 x 2.5 [cm], Unstageablei"  Medical record review of MDS dated 3/19/15 revealed the resident requires extensive assistance of 2 or more people for turning and positioning. Further review of the MDS revealed the resident had 1 Stage II Pressure Ulcer, 1 Stage III Pressure Ulcer and 2 unstageable Pressure Ulcers upon admission to the facility.  Medical record review of the TAR dated 3/2015 revealed "Right and Left HeelSureprep QD and PRNRight ButtockCleanse with WC, pat dry, apply Algimate Cover with Dry Dressing and change QD"  Medical record review of Head to Toe Skin Checks dated 3/19/15 revealed "Right Buttock, Pressure, 0.5 x 0.5 [cm]Right Heel, Pressure, 1.6 x 2.7 [cm], Unstageable"  Medical record review of Skin-Head to Toe Skin Checks dated 3/26/15 revealed "Right Buttock, Pressure, 0.0 [cm], depth 0 [cm]Right Heel, Pressure, 0.0 [cm], depth 0 [cm]Right	

DEL VIZTAIENT OL HEVELLI VIND LIOINIVIN PEKAICE?

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTICIOATION NUMBER			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
445268		445268	B. WING			C 03/31/2015	
	ROVIDER OR SUPPLIER NHEALTH AND REHABI	LITATION CENTER	1	7	STREET ADDRESS, CITY, STATE, ZIP CODE 21 CASTLE HEIGHTS COURT LEBANON, TN 37087		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 314	potential/actual skin i checks weekly per fa reposition frequently  Medical record review 3/27/15 revealed "a pressure ulcersSta unstageable to Bilate treatment as ordered effectiveness"  Medical record review 3/1/15-3/31/15 reveal to the right and left he 3/17/15 and 3/19/15.  Medical record review Medical record review 3/17/15 and 3/19/15.	ssuesInterventions:Skin cility protocolTurn and to decrease pressure"  w of Care Plan dated dimitted with several ge III Right Buttock and ral (both) Heels Administer and observe for  v of TAR dated ed pressure uilcer treatment rels was not documented on	F	314			
8	in the DON's office, w documentation on the	N on 03/18/15 at 11:40 AM hen asked about missing TARS, the DON stated, or TAR were missed or not					
F 441 SS=D	the DON's office, whe and infection control of nurses, the DON state expect nurses to use the knowledge." 483.65 INFECTION C SPREAD, LINENS	ONTROL, PREVENT	F 4	141	F441. Infection Control  1. Skin audit conducted on affected Reside treatment nurse and no negative outcomes observed due to alleged deficient practice. Conducted a one-on-one in-service with Nu	were rse#2	
	una nel Divisione Obse	loto Event ID: 1FGW11	y at the state of the state of	Fac	ility ID: TN9502 If continua	tion sheet	Page 35 of 50

PRINTED: 04/16/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING \_ C B. WNG 445268 03/31/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 731 CASTLE HEIGHTS COURT LEBANON HEALTH AND REHABILITATION CENTER LEBANON, TN 37087 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES In (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 441 Continued From page 35 F 441 regarding alleged deficient practice, and following Physician orders/protocols for skin treatments and safe, sanitary and comfortable environment and wound care. to help prevent the development and transmission of disease and infection. 2. Residents currently residing in facility with skin issues have the potential to be affected by alleged deficient practice. Skin audits on current (a) Infection Control Program residents were conducted by DON/Unit The facility must establish an Infection Control manager/ADON/charge nurses. No other Program under which it -Residents found to be affected by deficient (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, 3. DON/ADON/Designee will conduct visual audits on 2 treatments a week for 4 weeks, 2 should be applied to an individual resident; and treatments monthly x 2 months. to validate skin (3) Maintains a record of incidents and corrective treatments are performed as ordered by the actions related to infections. Physician and per Facility protocol. Education to Licensed Nurses related to wound staging, (b) Preventing Spread of Infection measuring of wounds, performing treatments (1) When the Infection Control Program using infection control standards, and determines that a resident needs isolation to documentation conducted by Michael Britton. Certified Wound Nurse and Dr. Powell, Wound prevent the spread of infection, the facility must Care Physician. isolate the resident. (2) The facility must prohibit employees with a 4. Any issues identified by the treatment audits communicable disease or infected skin lesions will be immediately addressed and corrective 05/10/2015 from direct contact with residents or their food, if measures taken for the Resident(s) affected. direct contact will transmit the disease. Results will be further discussed by the QAPI team, monthly x3, consisting of Administrator, DON, (3) The facility must require staff to wash their ADON, Unit Manager, Social Services Director, hands after each direct resident contact for which Medical Director, Dietary Manager, Maintenance hand washing is indicated by accepted Manager, Activities Director, and Medical Director. professional practice.

(c) Linens

infection.

by:

Personnel must handle, store, process and transport linens so as to prevent the spread of

This REQUIREMENT is not met as evidenced

Based on medical record review, observation, and interview, the facility failed to maintain

	VIAD LIGINIVIA OFIZATORS				FOR	AADDDOVED
	& MEDICAID SERVICES			0		M APPROVED
F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
	445268	B. WING	3_			С
OVIDER OR SUPPLIER			Г	STREET ADDRESS CITY STATE ZID CODE	03	/31/2015
	ABILITATION CENTER			731 CASTLE HEIGHTS COURT		
	IDICITATION GENTER			LEBANON, TN 37087		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
ontinued From pag	ge 36	F 4	44	1		
fection control pra	ctices during wound care for 1	•				
ne findings include	d:					
e resident was rea 8/03/15 with diagno ifficle, Chronic Kidr	dmitted to the facility on oses including Clostridium ney Disease, Generalized					
6/09/15 revealed " e) and outer calf, id soap, pat dry an isorbant dressing) RN (as needed)for eas (Healing Deep	Right outer thigh (donor Cleanse with warm water d cover with Optifoam (an QOD (every other day) and soiling Cover all scabbed Tissue Injuries) on heel and					
Resident # 3's room actical Nurse (LPN wn and mask and pplies. The nurse to e resident's room, e ocedure to the resi- nued clean gloves, realed the LPN the resonal belongings to ceeded to comple duding touching the ri-area, and separa- nealing coccyx presi- e wound care supple	m revealed Licensed  1) # 2 donned the isolation gathered the wound care hen knocked and entered explained the wound care dent, washed the hands and continued observation in moved the resident's from the bedside table and te a head to toe assessment e resident's ears, underarms, ated the buttocks to visualize ssure ulcer. The LPN placed lies on paper towels on the					
	SEPOR MEDICARE F DEFICIENCIES CORRECTION  DIVIDER OR SUPPLIER HEALTH AND REHA  SUMMARY STAT (EACH DEFICIENCY REGULATORY OR LS  ontinued From page fection control prace Resident #3) reside ressure ulcers. The findings include resident was rea 8/03/15 with diagnor resident was rea 8/03/15 with diagnor resident was rea 8/03/15 revealed " redical record revie resident was rea 8/03/15 revealed " redical record revie resident was rea 8/09/15 revealed " redical record revie resid	FOR MEDICARE & MEDICAID SERVICES F DEFICIENCIES CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445268  DVIDER OR SUPPLIER  HEALTH AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  ontinued From page 36 fection control practices during wound care for 1 Resident #3) resident of 7 residents reviewed for ressure ulcers.  The findings included:  edical record review of Resident #3 revealed are resident was readmitted to the facility on 8/03/15 with diagnoses including Clostridium ifficile, Chronic Kidney Disease, Generalized ain, Muscle Weakness, Anemia and Diabetes ellitus.  edical record review of Physicians Orders dated 1/09/15 revealed "Right outer thigh (donor e) and outer calf, Cleanse with warm water and soap, pat dry and cover with Optifoam (an esorbant dressing) QOD (every other day) and RN (as needed) for soiling Cover all scabbed as (Healing Deep Tissue Injuries) on heel and as with Sureprep (a skin protectant) BID (twice)	FOR MEDICARE & MEDICAID SERVICES F DEFICIENCIES CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445268  B. WINC  445268  B. WINC  WINC  WINC  WINC  HEALTH AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Ontinued From page 36 fection control practices during wound care for 1 Resident #3) resident of 7 residents reviewed for essure ulcers.  The findings included:  edical record review of Resident #3 revealed e resident was readmitted to the facility on 3/03/15 with diagnoses including Clostridium fficle, Chronic Kidney Disease, Generalized ain, Muscle Weakness, Anemia and Diabetes ellitus.  edical record review of Physicians Orders dated 3/09/15 revealed "Right outer thigh (donor e) and outer calf, Cleanse with warm water and soap, pat dry and cover with Optifoam (an sorbant dressing) QOD (every other day) and RN (as needed) for soiling Cover all scabbed eas (Healing Deep Tissue Injuries) on heel and es with Sureprep (a skin protectant) BID (twice illy)"  Discrevation of wound care on 3/19/15 at 1:40 PM Resident # 3's room revealed Licensed actical Nurse (LPN) # 2 donned the isolation win and mask and gathered the wound care poplies. The nurse then knocked and entered are resident's room, explained the wound care poplies. The nurse then knocked and entered are resident's room, explained the wound care poplies. The nurse then knocked and entered are resident's room, explained the wound care poplies. The nurse then knocked and entered are resident's room, explained the wound care poplies and the bedside table and coceded to complete a head to toe assessment luding touching the resident's ears, underarms, ri-area, and separated the buttocks to visualize lealing coccyx pressure ulcer. The LPN placed are wound care supplies on paper towels on the	FOR MEDICARE & MEDICAID SERVICES F DEFICIENCIES CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445268  DATE OF SUPPLIER  HEALTH AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Ontinued From page 36 fection control practices during wound care for 1 Resident #3) resident of 7 residents reviewed for ressure ulcers.  The findings included:  edical record review of Resident #3 revealed er eresident was readmitted to the facility on 30/3/15 with diagnoses including Clostridium fficle, Chronic Kidney Disease, Generalized ain, Muscle Weakness, Anemia and Diabetes ellitus.  edical record review of Physicians Orders dated 40/09/15 revealed "Right outer thigh (donor ere) and outer calf, Cleanse with warm water do soap, pat dry and cover with Optifoam (an insorbant dressing) QOD (every other day) and RN (as needed) for soiling Cover all scabbed as with Sureprep (a skin protectant) BID (twice illy)"  Deservation of wound care on 3/19/15 at 1:40 PM Resident # 3's room revealed Licensed actical Nurse (LPN) # 2 donned the isolation with and mask and gathered the wound care populies. The nurse then knocked and entered actical Nurse (LPN) # 2 donned the isolation with and mask and gathered the wound care populies. The nurse then knocked and entered are resident's room, explained the wound care populies. The nurse then knocked and entered are resident's room, explained the wound care populies. The nurse then knocked and entered are resident's room, explained the wound care populies. The nurse then knocked and entered are resident's room, explained the wound care populies. The nurse then knocked and entered are resident's room, explained the wound care populies and separated the buttocks to visualize realing coccyx pressure ulcer. The LPN placed are wound care supplies on paper towels on the	DORRECTION    A 19 PROVIDERS PPLEERCLA DENTIFICATION NUMBER:   (X2) MULTIPLE CONSTRUCTION   A BUILDING   (X2) MULTIPLE CONSTRUCTION   (X2) MULTIPLE CONSTRUCTION   A BUILDING   (X2) MULTIPLE CONSTRUC	FOR MEDICARE & MEDICAID SERVICES OMB NO POPULER CORRECTION  A 445268  DIVIDER OR SUPPLIER HEALTH AND REHABILITATION CENTER  SUMMARY STATEMENT OF DESCENCIES (EACH DEPTICENCY MUST BE PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION)  Ontinued From page 36 fection control practices during wound care for 1 Resident #3) resident of 7 residents reviewed for ressure ulcers.  The findings included:  edical record review of Physicians Orders dated 4/09/15 revealed "Right outer thigh (donor e) and outer calf, Cleanse with warm water do soap, pat dry and cover with Optifoam (an sorbant dressing) QDD (every other day) and RN (as needed) for soiling Cover all scabbed eas (Healing Deep Tissue Injuries) on heel and as with Sureprep (a skin protectant) BID (twice illy)"  Deservation of wound care on 3/19/15 at 1:40 PM Resident #3's room revealed Licensed actical Nurse (LPN) #2 donned the isolation win and mask and gathered the wound care polies. The nurse then knocked and entered residents from, explained the wound care polies. The nurse then knocked and entered resident form, explained the wound care polies. The nurse then knocked and entered residents from, explained the wound care polies. The nurse then knocked and entered residents from, explained the wound care polies. The nurse then knocked and entered residents from, explained the wound care polies. The nurse then knocked and entered residents from, explained the wound care polies. The nurse then knocked and entered residents from, explained the wound care polies. The nurse then knocked and entered residents from, explained the wound care polies. The nurse then knocked and entered residents from, explained the wound care polies. The nurse then knocked and entered residents from, explained the wound care polies. The nurse then knocked and entered residents are supplied to paper towels to suitable earlier.  Resident provided the provided the page towels to the suitable and towelded to complete a head to toe assessment luding louching the resident's care

PRINTED: 04/16/2015 FORM APPROVED

		I				OMB N	O. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		445268	B. WNG			0.2	C
	ROVIDER OR SUPPLIER	ITATION CENTER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 31 CASTLE HEIGHTS COURT EBANON, TN 37087	1 03	31/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 441	right posterior thigh C placed it in the trash of right thigh with water Without changing the removed the dressing proceeded to touch a drainage was noted. I gloves, placed the dre washed the hands an Certified Nurse Assist resident's uncovered, the soiled bed linens. to the right ankle and revealed LPN # 2 rem mask and gloves and	ne LPN removed the soiled optifoam dressing and can. The LPN cleaned the and patted the area dry. soiled gloves, the LPN then from the right calf, and squeeze the wound, and the LPN removed the soiled essing in the trash can, and donned clean gloves. The ant (CNA) allowed the right calf wound to touch the LPN applied SurePrep toe. Continued observation oved the isolation gown, disposed of them in the red sanitizer on the hands and	F	441			
F 514 SS=E	the DON's office, whe and infection control of nurses, the DON state expect nurses to use the knowledge." Continue when asked "do you had dressing changes?", the facility has a policy wounds. The DON coupolicy or procedure or 483.75(I)(1) RES RECORDS-COMPLE The facility must main	ed interview with the DON, ave a policy for doing the DON stated, "just the he DON was also asked if or procedure for treating enfirmed the facility has no a wound treatment.  TE/ACCURATE/ACCESSIB  tain clinical records on each a with accepted professional	F	514	F514. Clinical Records  1. R # 3 had skin audit and documentation to reflect current skin concern on 4/22/15. Residents# 1,2,5,6, no longer reside in facility.	o.	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DAT	E SURVEY
		445000		- <del></del>			С
NAME OF D	DOMBED OF GUIDNIES	445268	B. WNG			0:	3/31/2015
	ROVIDER OR SUPPLIER  N HEALTH AND REHABIL	ITATION CENTER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 31 CASTLE HEIGHTS COURT EBANON, TN 37087		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE
	The clinical record mu information to identify resident's assessmen services provided; the preadmission screening and progress notes.  This REQUIREMENT by: Based on medical recovered weekly pressure ulcer facility failed to maintal clinical records for 5 (Resident #3, Resident residents reviewed.  The findings included: Medical record review admitted to the facility the hospital on 3/1/15, discharged back to the diagnoses including President Failure, Hyperter Hemiplegia.  Review of the facility parevision date of 9/11 orders are obtained to regarding the care of the residentDiscipline-sp	ed; readily accessible; and red.  ast contain sufficient the resident; a record of the ts; the plan of care and results of any ng conducted by the State;  is not met as evidenced cord review, review of the log, and interview the in accurate, complete Resident #1, Resident #2, #5 and Resident #6) of 7  revealed Resident #1 was on 2/27/15, discharged to re-admitted on 3/5/15 and a hospital on 3/16/15 with neumonia, Congestive nsion, and Flaccid  olicy Physician Orders with revealed "Physician provide clear direction ne ecific treatment orders can d health care professional, itialed and dated by a redeging receipt and	F	514	<ol> <li>Residents who have skin concerns have to potential to be affected by this alleged deficiential audit of TARS conducted by DON/ADON/Unit Manager/treatment nurse for documentation and assessments completion/accuracy. Corrective actions take for Residents identified with missing documentation/assessments regarding skin as skin concerns.</li> <li>Skin audits will be scheduled Sunday through a skin concerns.</li> <li>Skin audits will be reviewed in Morning me Monday through Friday. Any not completed we done immediately and education provided to Licensed nurses. Treatment nurse is currently place to oversee treatment implementation and documentation. Second Documentation review Monday through Friday, conducted by Don/Unmanager /ADON/MDS nurse. Education to Lice Nurses related to wound staging, measuring owounds, performing treatments using infection control standards, and documentation conductly Michael Britton Certified Wound Nurse and Powell Wound Care Physician with post-test competency.</li> <li>Audits of TARS of residents with wounds were conducted 3 times weekly x 4 weeks. Conce will be reported to monthly x 3 to the QAPI committee consisting of Administrator, DON, ADON, Unit Manager, Social Services Director, Medical Director, Dietary Manager, Maintenan Manager, Activities Director, and Medical Director.</li> </ol>	ency.  or  an  nd  ough eting will be  y in  nd  www,  nit ensed f  n  cted I Dr.  will es a  cerns	05/10/2015

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	5.0000000000000000000000000000000000000		E CONSTRUCTION	(X3) DAT	E SURVEY
		445268					С
NAME OF P	ROVIDER OR SUPPLIER	443260	B. WNG		TREET ADDRESS SITE OF THE SAME	03	3/31/2015
	N HEALTH AND REHAB	ILITATION CENTER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 31 CASTLE HEIGHTS COURT LEBANON, TN 37087		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		2000000000	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		E XTE	(X5) COMPLETION DATE
F 514	Continued From pag		F	514			
	3/31/15 revealed a v "Santyl (wound me UNIT/GM (gram) (Co Wound topically ever for Sacral wound Cle cleaner), pat dry, cov Sureprep (wound tre bed only), cover with change QOD (every needed) for soiling no documentation fo treatment was noted notation for 3/9/15 re Condition" No doc	rd (TAR) dated 3/1/15- rerbal order dated 3/6/15 for redication) Ointment 250 pollagenase) Apply to Sacral ry day shift every other day reanse with WC (wound rer wound boarder with atment), apply Santyl (wound re Hydrocolloid dressing, and other day) and PRN (as " Continued review revealed r wound care/ pressure ulcer on 3/7, 3/9, or 3/11/15. The revealed "3=Hold due to umentation as to what the					
	Medical record review Charting dated 3/7, 3 documentation regar resident and a "No" w in the resident's Skin Nursing Daily Skilled	th warranted holding the ald be found.  w of the Nursing Daily Skilled (10, and 3/16/15 revealed no ding skin changes to the was marked for any changes Integrity. There were no Charting notes for 3/6, 3/8, 3/14 and 3/15/15 for the					
	for the week of 3/5/18 an unstageable press measuring 6 x 8 x 0.3 with Santyl and a hydweek of 3/13/15 docuunstageable cluster pressuring 6 x 7.5 x 0 with Santyl and a hydroxidal process of the santyl and a hydrox	y Pressure Ulcer QA & A Log 5 revealed the resident had sure ulcer of the sacrum 8 cm and was being treated drocolloid dressing. The mented the resident had an pressure ulcer to the sacrum 0.3 and was being treated drocolloid dressing QOD. The mals or signature of the person					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		445268	B. WNG		03/31/2015	
	ROVIDER OR SUPPLIER  N HEALTH AND REHABII	LITATION CENTER	73	TREET ADDRESS, CITY, STATE, ZIP CODE 31 CASTLE HEIGHTS COURT EBANON, TN 37087		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 514	documenting the would treatment.  Interview with LPN #3 the conference room obtaining and transcricare Specialist as foll with the physician one each resident noted to physician describes, in the wound, and gives nurse records it on he then reviews it with the completed and re-write Pressure Ulcer QA & Non-Pressure Ulcer QA & Non-Pressure Ulcer QA another copy for the pweek when he rounds there was no hand with back, note off, or have and kept as permaner resident's medical recommendated 3/6/15 and no truntil 3/13/15. The DOI inconsistencies in the resident's pressure ulceft gluteal fold versus measurements of the 7 x 10.2cm versus 6 x in descriptions i.e., but skin versus unstageat interview with the DOI thereview with the DOI the conference room of the conference room	and site, staging, size and  3 on 3/30/14 at 2:55 PM in confirmed the process for ibing orders from the Wound lows: This nurse rounds are a week on Thursdays to have a wound. The measures, stages and treats a verbal order and the er own piece of paper. She have it onto the Weekly A Log or the Weekly A Log or the Weekly A Log. From there she to order into the computer, and only sician to sign the next again. The LPN confirmed itten verbal order to read a checked by another nurse and documentation in the cord.  N on 3/31/15 at 5:20 PM in confirmed Resident #1 had a pressure ulcer treatment reatment was documented N also acknowledged the	F 514			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		445268	B. WNG			C 3/31/2015
	ROVIDER OR SUPPLIER  NHEALTH AND REHABIL	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 731 CASTLE HEIGHTS COURT LEBANON, TN 37087		5/5 1/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 514	as the incomplete char of the daily assessme 3/16/15. Further interprocess that LPN #3 of transcribing treatment Care Specialist. The Education of the down a verbal just type it right into the Medical record review admitted on 10/4/11, redischarged on 10/20/17 record review revealed Anemia, Hyperlipidem Hypothyroidism, Pneu Infection, Arthritis and Medical record review for pressure ulcers daily 7/17/14, 10/6/14 and 1/2 approach to "complete and document."  Continued medical record review for Deskin Checks we 2/19/14, 2/26/14, 3/5/17/14/14, 8/4/14, 8/11/11 9/22/14, 10/13/14, and Medical record review Check dated 7/28/14 rean abrasion to the left Review of a facility Incidated 8/8/14 revealed	ent was in the facility, as well arting under the skin section int on 3/7, 3/10, and view confirmed the same described in obtaining and corders from the Wound DON stated, "You don't have order anymore, you can be computer."  It revealed Resident #2 was readmitted on 5/7/12, and 14. Continued medical diagnoses including ia, Depression, imonia, Urinary Tract Coronary Artery Disease.  In of the resident's care planted 4/17/14 and updated 10/18/14 revealed and a full body check weekly cord review of the weekly	F	514		

AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Total Control of the	IPLE CONSTRUCTION		SURVEY PLETED
		445268	B. WNG		100000	С
255000000000000000000000000000000000000	ROVIDER OR SUPPLIER  N HEALTH AND REHABIL	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 731 CASTLE HEIGHTS COURT LEBANON, TN 37087	1 03.	/31/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPE  DEFICIENCY)	BE	(X5) COMPLETION DATE
F 514	Review of a facility Indicated 9/8/14 revealed has increased in size.  Review of the Weekly dated 9/21/14 revealed. III pressure ulcer to the x 0.4 cm and a Stage buttock measuring 2.4 Review of the Weekly dated 9/28/14 reveale. III pressure ulcerto the 1.0 x 0.4 cm and a Staleft buttock measuring. Review of the Weekly dated 10/6/14 reveale. III pressure ulcerto the 1.0 x 0.4 cm and a Staleft buttock measuring. Medical record review. Ulcer Record dated 9/2 documentation of a prebuttock ("closest to ou x 0.2 cm (no stage documentation) measuring 1.4 Medical record review. Ulcer Record dated 10 documentation of a preclosest to inside) measuring 1.4 medical record review. Ulcer Record dated 10 documentation of a preclosest to inside)" measuring 1.4 medical record review.	cident/Accident Report "wound on left buttock - worse in last few days."  Pressure Ulcer QA&A d Resident #2 had a Stage e coccyx measuring 1.4 x 1 II pressure ulcer to the left e x 1.6 x 0.2 cm.  Pressure Ulcer QA&A d Resident #2 had a Stage e coccyx measuring 1.0 x age II pressure ulcer to the 1.2 x 2.0 x 0.2 cm.  Pressure Ulcer QA&A d Resident #2 had a Stage e coccyx measuring 1.0 x age II pressure ulcer to the 1.2 x 2.0 x 0.2 cm.  Pressure Ulcer QA&A d Resident #2 had a Stage e coccyx measuring 1.0 x age II pressure ulcer to the 2.8 x 2.0 x 0.2 cm.  of the Weekly Pressure 26/14 revealed essure ulcer to the right tside")measuring 2.4 x 1.6 cumented) and a Stage III ght buttock (closest to x 1.0 x 0.4 cm.  of the Weekly Pressure	F5			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVE	Υ
	445268	B. WNG			С	
NAME OF PROVIDER OR SUPPLIER  LEBANON HEALTH AND REHABILIT		J. WING	STREET ADDRESS, CITY, STATE, ZIP CO 731 CASTLE HEIGHTS COURT LEBANON, TN 37087	DDE	03/31/20	15
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (	COMP	X5) PLETION ATE	
3/29/15 at 10:15 AM in confirmed the Weekly F description of the reside description of the wound plan were inconsistent.  Medical record review of Skin checks revealed not completed on Resident Continued review reveal Ulcer Record document for the weeks of 8/18, 8 and 10/13/14 after the reports revealed weekly completed for Resident Medical record review of for pressure ulcers revealed at " Stage II led update on 9/8/14 to reflect a " Stage II led update on 10/18/14 to reflect a " s	ctor of Nursing (DON) on the DON's office, the DON Pressure Ulcer Record ent's wounds and the ends on the resident's care  of the Weekly Head to Toe of skin checks were with a state of the Weekly Pressure that the ends of the Weekly Pressure that the ends of the Weekly Pressure ulcers with a state of the Weekly Pressure ulcers with a state of the was identified to the ends of the was identified to the ends of the resident's care plant and an update on 8/8/14.  Of the resident's care plant and an update on 8/8/14 with endial buttock"; and the ends of	F 5	514			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		445268	B. WNG		С
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 731 CASTLE HEIGHTS COURT LEBANON, TN 37087	03/31/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 514	of the TAR revealed per were not documented 9/10, 9/13, and 9/16/ Medical record review 9/26/14 revealed and buttock with wound continued reverse was no documented of this pressure ulcer administered.  Medical record review revealed a treatment coccyx with wound clewound bed and pack with Optifoam" Con revealed pressure ulcomevealed pressure ulcom	3 days" Continued review pressure ulcer treatments of on the following dates: 14.  If of physician's orders on order to "clean wound on leaner, pat dry, apply Thera of Optifoam" every 3 days. entation on the 9/2014 TAR treatment being  If of the 10/2014 TAR treatment being  If of the 10/2014 TAR treatment being with Maxorb rope, cover tinued review of the TAR er treatment was not 1/14.  If TAR revealed a treatment earight buttock with wound el and cover daily"  If TAR revealed pressure not documented on 10/16  If on 3/31/14 at 6:30 PM in confirmed wound rovided as ordered by the of Resident #3 revealed mitted to the facility on	F 51	4	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3	3) DATE SURVEY COMPLETED
		445268	B. WING			С
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 731 CASTLE HEIGHTS COURT LEBANON, TN 37087		03/31/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 514	3/9/15 revealed "Rig outer calf, Cleanse wi pat dry and cover with other day)and PRN for areas (Healing Deep toes with Sureprep (a daily)"  Medical record review 3/1/15-3/31/15 reveals Injury (DTI), cover scatoes with Sureprep BI TAR dated revealed p the "heel and toes" wa 3/7 and 3/10/15.  Interview with the DOI the DON's office confi were missing pressure documentation, and the fordocumentation are itthere is an issue with the resident was read 2/19/15 with diagnose Healing Traumatic Framellitus, Congestive Heibrillation (abnormal Weakness and Difficul Medical record review Data Collection dated Assessment: Coccyx,	of a TAR entry dated ght outer thigh (donor site), th warm water and soap, a Optifoam QOD (every or soilingCover all scabbed Tissue Injuries) on heel and skin protectant) BID (twice of a TAR dated ed "Healing Deep Tissue abbed areas on heel and D. Continued review of the ressure ulcer treatment to as not documented on 3/6,  N on 3/18/15 at 11:40 AM in red blanks on the TAR elucer treatment to be DON stated, "I looked and was unable to find	F 5	14		

	EMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING  A. BUILDING		(X3) DATE SURVEY COMPLETED				
		445268	B. WING	534		1	С
NAME OF P	ROVIDER OR SUPPLIER	443200	B. WING			03	/31/2015
	HEALTH AND REHABIL			7	TREET ADDRESS, CITY, STATE, ZIP CODE 31 CASTLE HEIGHTS COURT EBANON, TN 37087		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 514	dated 2/27/15 reveals with wound cleaner, protectant) to wound (topical ointment aids bed only and cover wother day) and PRN  Review of a physiciar revealed "Sacrum cleaner, pat dry, apply borders, apply Santyl cover with dry dressin Medical record review dated 3/3/15/15 reveals with wound cleaner, paure prep and cover v (every day) and PRN.  Review of a physician revealed "Left Heel cleaner, pat dry, apply borders, apply Santyl Alginate (an absorber cover with dry dressin for soiling"  Medical record review 2/1/15-2/28/15 reveals to the left heel was not Review of a TAR date	of a physician's order ad "Left heel Cleanse at dry, apply SurePrep (skin borders, apply Santyl in wound healing) to wound ith dry dressing QOD (every "."  of sorder dated 2/27/15 Cleanse with wound y SurePrep to wound to wound bed only and go QOD and PRN"  of a physician's order alled "Right HipCleanse at dry, coat staple line with with long boarder gauze QD for soiling"  of sorder dated 3/3/15Cleanse with wound y sure prep to wound to wound bed only, apply at wound dressing), and go (not foam) QOD and PRN  of a TAR dated and pressure ulcer treatment to documented on 2/28/15.  d 2/1/15-2/28/15 revealed and to the left sacrum was 1/28/15.	F	514	Disclaimer  Submission of this response and plan of co is not a legal admission that deficiency exist that this statement of deficiencies was concited, and is also not to be construed as an admission of interest against the facility, the Executive Director, or any employees, ager other individuals who draft or may be discuthis response and plan of correction. In adpreparation and submission of this plan of correction does not constitute an admission agreement of any kind by the facility or the correctness of any conclusions set forth in tallegation by the survey agency. According facility has prepared and submitted this placorrection prior to the resolution of any appropriate in the plan of correction (10) ten days of the survey as a condition to participate in Title 18 and Title 19 programs submission of the plan of correction within the frame should in no way be considered construed as agreement with the allegations non-compliance or admissions by the facility plan of correction is submitted by the facility plan of correction is submitted by the facility credible allegation of compliance.	e ts, or essed in dition, of his y, the n of his within	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	SURVEY PLETED
		445268	B. WNG				C (34/2045
	ROVIDER OR SUPPLIER	ITATION CENTER		7:	TREET ADDRESS, CITY, STATE, ZIP CODE 31 CASTLE HEIGHTS COURT EBANON, TN 37087	[ 03/	/31/2015
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BI TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			(X5) COMPLETION DATE
F 514	3/1/15-3/31/15 reveal to the left heel was not and 3/21/15.  Review of a TAR dated pressure ulcer treatment documented on 3/21/15.  Review of TAR dated pressure ulcer treatment documented on 3/7/18 and 3/18/15.  Interview with the DO the DON's office confit were missing pressure documentation and the fordocumentation and itthere is an issue with the modern treatment of the modern t	ed pressure ulcer treatment of documented on 3/10/15  ad 3/1/15-3/31/15 revealed ent to the left sacrum was 1, 3/2, 3/3, 3/4 and 3/11/15.  3/1/15-3/31/15 revealed ent to the right hip was not 5, 3/10/15, 3/11/15, 3/13/15  N on 3/18/15 at 11:40 AM in rmed blanks on the TAR endicer treatment end blanks on the TAR endicer treatment end was unable to find ith documentation."  To f Resident #6 revealed ented to the facility on its including Recent Right endicated to the facility on its including Right endicated to the facility on its	F	514			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		445268	B. WING			C 03/31/2015	
NAME OF PROVIDER OR SUPPLIER  LEBANON HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 731 CASTLE HEIGHTS COURT LEBANON, TN 37087			31/2015
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		100000000000000000000000000000000000000	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 514	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	514			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		445200	D MANO			19	С
NAME OF P	ROVIDER OR SUPPLIER	445268	B. WNG _		TOTAL ADDRESS OF A COLUMN	03	31/2015
NAME OF PROVIDER OR SUPPLIER  LEBANON HEALTH AND REHABILITATION CENTER				73	TREET ADDRESS, CITY, STATE, ZIP CODE 31 CASTLE HEIGHTS COURT EBANON, TN 37087		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHOI TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)		BE COMPLETION	
F 514	11:00PM.  Medical record review Checks dated 3/19/15 Pressure, 0.5 x 0.5 cn x 3.0 cm, Unstageable  Interview with the DOI the DON's office confi were missing pressure documentation and the	of Head to Toe Skin is revealed "Right Buttock, nRight Heel, Pressure, 1.7 e; Left Heel, Pressure, 1.6 x"  N on 3/18/15 at 11:40 AM in rmed blanks on the TAR e ulcer treatment e DON stated, "I looked for was unable to find it	F	514	DEFICIENCY)		
		1				1	- 1